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CLINICAL LECTURE.

A CLINICAL LECTURE ON SOME EVERY-DAY CASES OF DISEASES OF THE EYE.[1]

BY HOWARD F. HANSELL, M. D.,
CHIEF OF CLINIC.

Occlusion of Canaliculi.

Gentlemen: The Professor of Ophthalmology in unavoidably absent to-day, and has requested me to occupy his hour.

The first case is one of acquired occlusion of the canaliculi. The patient lost her right eye through scarlet fever at four years of age. She presented herself at this clinic several weeks ago, to consult us as to the advisability of wearing an artificial eye. Upon examination it was found that the commissure of the lids had been shortened by an obliteration of the inner canthus. The eyeball was atrophied, reduced to nearly one-half the size of its fellow and slightly painful on pressure in the ciliary region. She was advised that an artificial eye might light up an already smouldering inflammation and induce sympathetic ophthalmia; moreover the eye was hopelessly blind and unsightly. The ball was enucleated in your presence by Prof. Thomson. Healing progressed favorably. A few days later the inner canthus was restored to its normal size by a plastic operation, but the canaliculi were replaced by cicatricial tissue. She now wears a glass eye and is greatly improved in appearance, but complains of constant overflow of tears. With a Graefe knife I now divide the cicatrix over the obliterated lower canal, thrusting its point inward as far as the nasal bone. With a probe the opening is enlarged. The latter process must be repeated several times during the next week, to prevent the walls of the new canal from growing together.

[1] Delivered at the Jefferson Medical College Hospital, January 16, 1890.

Stricture of the Lachrymal Duct.

This patient makes the same complaint we heard in the preceding case, but here the epiphora is due to a closure of the duct in one or more places by inflammatory thickening of the mucous membrane which lines it. Its cause might be found in some co-existing nasal catarrh or hypertrophy of the nasal mucous membrane, but frequently we are at a loss to establish a cause. As in the former case, I insert the point of a Weber's knife into the lower puncture, thrust it along the canal until it reaches the sac, and elevate the handle, thus making the canal a gutter. I then pass the knife down though the duct, dividing the stricture. This must be followed through several weeks by probing.

Lachrymation is a symptom or an accompaniment of many eye diseases, such as conjunctivitis, keratitis. Chronic lachrymation, or a constant overflow of tears, is unusual, unless as a symptom of chronic conjunctivitis, an everted lower lid or closure of the lachrymal canal. In the last condition only do we resort to the above operation. In old cases collection of pus and muco-pus constantly form in the sac, and are easily expressed. In such cases no doubt as to the diagnosis can exist. The result of the divulsion of the stricture either by knife or probe is not always favorable. Indeed I venture to assert, that few operators have been satisfied with their experiences. The treatment is painful, long continued and often unsuccessful, so that, as a final resort, a canulated silver style must be worn.

Soft Cataract.

The next case is one of soft cataract. This patient was treated by me several years ago for iritis serosa with dense vitreous opaci-

ties in the left eye without success. A cataract developed in the interval, and he now returns to have it removed. He is only twenty-five years old. Therefore, although the cataract is mature, the lens is soft and cannot be extracted according to the method pursued in the treatment of cataracts recurring after the age of forty or thereabouts. It must be needled, and usually more than once. While this procedure is extremely simple, it is not unattended with danger. Some of you may remember a similar case last winter in a healthy man, aged 25, who suffered with congenital cataract. After needling, glaucoma developed, and notwithstanding sclerotomy and iridectomy we were compelled to enucleate the ball on account of the dangerous condition to which the man was reduced, having lost twenty-five pounds in two weeks. I have warned this patient of the dangers and given rather an unfavorable prognosis, in view of the preceding inflammation, and he is willing to take the chances. The ball is free from injection, light projection is good and temperature is normal. I introduce a stop needle half-way between the centre of the cornea and its periphery, into the pupil dilated with atropine, and thrust it into the lens. By moving the point of the needle in various directions the lens is broken up and protrudes into the anterior chamber through the ruptured capsule. If the wound in the capsule remains open, the cataract will become absorbed; if not, the operation must be repeated.

Blindness from Neglected Iritis.

The next case is one of great interest, and I would ask you to give it your particular attention. Mary N., thirty years old, is nearly blind in both eyes from the effects of old iritis. In order that you may have a clear idea how this sad condition has resulted from an inflammation, which under proper and timely treatment would have been cured, please follow me closely in the brief consideration of the pathological changes that have here taken place. Inflammation of the irides, probably of syphilitic origin, developed two years ago, leaving the vision considerably obscured through exudation into the pupils. The papillary margins became totally adherent to the lens capsules, closing the channels of communication between the posterior and anterior chambers, compelling retention of normal secretion in the posterior chambers with consequent enlargement of those chambers by bellying forward of the irides and closure of the angle between the iris and the cornea. The adhesions or posterior synechiæ have been constant causes of recurring attacks of iritis, each of which caused still further deterioration of vision. To-day we find the ciliary vessels injected, the anterior chambers shallow, the pupils almost occluded, the fields of vision concentrically limited and central vision greatly deteriorated. Secondary glaucoma is threatening and will certainly develop unless the channels of communication are re-established by an iridectomy in each eye. I find the operations difficult, on account of the firm posterior synechiæ, but I am gratified to see that the new pupils are clear, the exudation being confined to the papillary margins.

This case conveys two important lessons to you as future practitioners. In iritis, keep the pupils dilated by means of frequent applications of strong solutions of atropine; in circular or annular synechiæ perform iridectomy.

Internal Strabismus.

I have to show you, lastly, a case of internal squint. As you are aware nine-tenths of all cases of this affection are the result of hypermetropia, and in most of them one eye is amblyopic. This patient has hypermetropia and astigmatism, which have been corrected during paralysis of accommodation. The vision of one, the fixing eye, improved to normal. The other, the squinting eye, to one-fifth only. The operation is undertaken chiefly for cosmetic purposes; for although the axes of vision should be made parallel, I have no anticipation of improving the vision in the amblyopic eye. By careful division of the conjunctiva of the tendon at its attachment to the sclera, and of the tendinous fibers which sometimes form broad lateral attachments, the effects of the operation may be safely regulated; and hence I always prefer in both high and low degrees of apparent abnormal convergence to operate on both internal recti. I will carefully sever each tendon, using the small hook, suggested by Stevens, rather than the large one commonly employed.

—Arecoline, the volatile liquid alkaloid of the areca nut principally affects the heart. It is excreted unchanged.

COMMUNICATIONS.

CONSTRUCTION AND ADAPTATION OF SPECTACLE-FRAMES.[1]

BY CHARLES HERMON THOMAS, M. D.,
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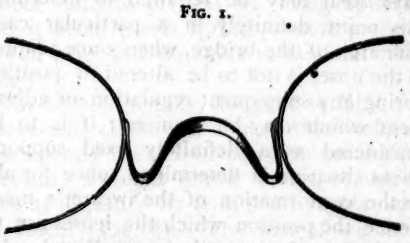
The treatment of ocular defects by means of glasses involves, beside the optical correction, a factor of no less practical importance—their mechanical adjustment. The purpose of the present paper is to direct attention to some of the mechanical aspects of the subject, particularly to the principles involved, and to certain methods of mounting spectacle-glasses. The results of the most accurate refractive measurements may be entirely vitiated by a faulty position of the correcting glasses; not only so, but new sources of eye-strain may be created by the very means adopted to remove an existing fault. Correcting glasses are remedial agents, just as orthopedic appliances are, and, as such, are powerful for evil as well as good, and hence everything belonging to them falls within the duty of the prescribing physician. The optical centre of a lens is generally that part of the glass which we wish to bring before the pupil, as it and the part of the lens immediately surrounding it are freest from aberrations of all sorts—distort least. Occasionally, however, it may be desirable to displace this point by a definite amount; in any case, we should insist on having the optician carry out our directions as regards the manner of mounting and the position of the glass with the same exactness that he employs in making it of the proper strength.

The purpose of the spectacle-frame is to hold a pair of glasses before the eyes in a definite position and with the least possible annoyance to the wearer. To accomplish this, I devised a plan about thirteen years ago (1878) for the construction of spectacle-bridges, which plan provides especially for a wide range of adaptability and the consequent accurate adaptation of spectacles to individual faces of almost every conceivable form. No account of the principles involved has heretofore been published, so far as is known, although some special forms of the bridge, as originally made under my direction, have come into almost universal use, being known throughout the optical trade under the name saddle-bridge.

Previous to the introduction of this bridge it was not practicable to obtain spectacle-frames suitable for persons with unusual forms of nose or face or with excessively prominent eyes or long lashes. Then, beside the ordinary "regular bridge," there was nothing better in use than the "X-bridge" or the equally unsatisfactory "snake-bridge," in both of which the combined weight of the glasses and frames was often borne directly upon the crest of the nose, besides which they usually failed to place the glasses in the correct position before the eyes. Few could wear either of the latter with comfort, and those who succeeded often did so only by padding them with wrappings of thread, thus making an unsightly cushion at the point of contact with the nose. The bridge (Fig. 1) under the plan

FIG. 1.



Saddle-bridge—typical form (back view).

referred to consists of (1) a nose-piece of arched form, of flattened wire and made to conform accurately to the shape of the nose at a definite point of selection, crossing the bridge of the nose at right angles and so resting saddle-wise upon it—whence its name. (2) A pair of adjustable return-pieces or arms, to the extremities of which are attached the rims or clasps carrying the glasses. These arms are produced by bending outward upon themselves the limbs of the wire from which the arch of the bridge has been formed, and are given whatever special direction may be required to place the glasses in the desired position before the eyes of the individual wearer. The bridge consists, then, of an arch and two adjustable arms, which, while fixing the glasses in their proper position before the eyes, should furnish as nearly an immovable support as possible.

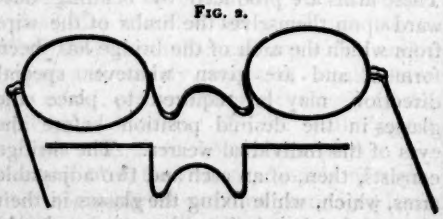
The bridge of the nose close to its root being the basis of support, the spectacle-bridge must be constructed with reference to this part. The wire of which it is made

[1] Read before the Philadelphia County Medical Society, February 11, 1891.

should be wide at the middle and taper towards each end, so as to make the bridge widest where it takes its bearing on the sensitive part of the crest of the nose. Narrowing the extremities is of special advantage, as it facilitates any necessary bending at that point in the process of adjustment. The sides of the arch should embrace the nose snugly without undue pressure, and extend well back towards the inner canthus, but not far enough to press upon the lachrymal sac. The saddle, or arch, as thus described, becomes the fixed support when it rests in its proper position. This position varies considerably in different persons, though on every nose there is usually one best point which should be sought—the point of selection, it may be termed. Unless the arch be adjusted to this particular point, the wearer will be rendered uncomfortable, and be continually shifting his spectacles. A few days' wear may be required to determine this point definitely in a particular case. The arch of the bridge, when once adapted to the nose, is not to be altered in position during any subsequent regulation or adjustment which may be required; it is to be considered as a definitely fixed support, whose situation is determined, once for all, by the conformation of the wearer's nose. Hence the position which the lenses are to take before the eyes does not directly depend upon the arch, but rather upon the length and direction of the adjustable arms attached to it, by variations in which the glasses may be made to take any required position. The arms are to be made long or short, they may be set high or low, pointed inward or outward, according to the requirements of any given case.

If the eyes be specially prominent, and the bridge of the nose be low, thus causing

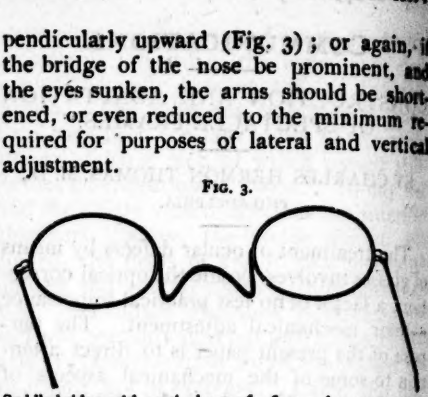
Fig. 2.



Saddle-bridge, with horizontal arms; for prominent eyes and long lashes.

the lashes to project beyond the level of the nose, the arms must be made relatively long (Fig. 2); or if the bridge of the nose be low or flat, and the eyes be placed relatively high it may be required to direct the arms perpendicularly upward (Fig. 3); or again, if the bridge of the nose be prominent, and the eyes sunken, the arms should be shortened, or even reduced to the minimum required for purposes of lateral and vertical adjustment.

Fig. 3.



Saddle-bridge, with vertical arms for flattened nose; eyes high.

The height of the eye as related to the part of the nose on which the arch rests—the point of selection—determines the amount of slant, if any, to be given to the arms. In practice it is found that in by far the larger proportion of cases the arms are nearly horizontal, slanting slightly upward; in exceptional cases they slant downward below the horizontal; and in rare instances it is necessary to give them an almost perpendicular direction upward. The angle which the arms make with the clamp or rim carrying the glasses must vary according to the directions of the arms, in order to keep the plane of the glasses perpendicular to the visual lines. The arm, where it is soldered to the rim, or the clasp of frameless glasses, is slightly bent in an upward direction. Increasing or diminishing these curves changes the position of the glasses vertically, and so compensates for any degree of upward or downward slant of the arms. This may be necessary where, for example, the point of selection of the arch is low down on the nose; the arms must then ascend vertically to raise the glasses to a level with the eyes; but this position of the arms will cause the glasses to assume an approximately horizontal direction—parallel to the visual lines—if the arms meet the rim at or about a right angle, as they usually do; in such a case, the arm must be bent so as to join the lens at an oblique angle or even lie in the plane of the lens.

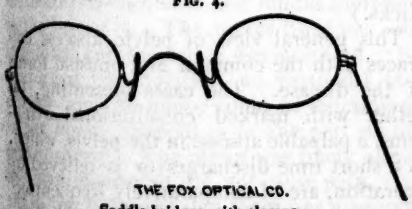
The proper adjustment of a pair of spectacles in ordinary cases is largely determined, as we have seen, by the length and direction of the arms. In special cases, also, as in asymmetry of the face, the compensation required is to be effected by the same means. In some cases the arms may need to be of unequal length. It is of frequent occurrence

that the centres of the pupils on the two sides are unequally distant from the centre of the arch. When this condition exists it is to be met by varying the direction and, it may be, also the length, of the arms. It is important from the point of view of the optician, to note that the principle adaptations of the bridge are preferably to be made extemporaneously and with the patient present. In this way, with a variety of sizes of the typical form at hand, the skilful mechanic is able to produce any particular modification which may be required without specially constructing the frames, even for atypical faces. It is often desirable to take the conformation of the nose at the point of selection. This may conveniently be done with lead wire, and the outline thus obtained may—by "rubbing"—be made a part of the record of the case.

Variations in the size of the lenses employed will also necessitate modifications in the lateral adjustment of the arms. To get the advantages of a large glass in cases where the distance between the eyes is relatively small, the arms will have to be bent inward—made to approach each other. The opposite direction may have to be given them in cases of unusual width of face. Lateral supports, or clamps, which take their bearing lengthwise on the sides of the nose near the base, as in eye-glasses of the best construction, have occasionally been employed by others in combination with spectacle-frames, but usually in form and by mechanical means not wholly satisfactory.

I have recently had made by the Fox Optical Company a combination of the eye-glass clamps with the saddle-bridge (Fig. 4), which is neat and simple in construction,

Fig. 4.

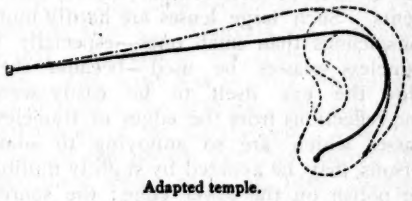


Saddle-bridge: with clamps.

and which combines the advantages of both in great degree. The attachment is so made as to preserve the adjustability both of the bridge and the clamps. The special advantage of this combination is that it distributes the pressure over a larger surface, and upon parts better able to sustain it than does the arch of the bridge alone.

The side-pieces, or temples, should be specially adapted to the ear with as much care as the bridge is to the nose in each individual case. They should be hooked around the ears for constant use and be so formed as to retain the bridge at the point of selection on the nose, and thus secure a fixed position of the entire appliance. The

Fig. 5.



Adapted temple.

curve of temples, as ordinarily made, is of far too great a radius. It takes its bearing behind the ear upon a limited surface, and so is liable to cut; it fails to secure a proper hold to prevent its riding upward, and it often exerts spring-pressure productive of pain and injurious to ears and nose alike.

An adapted temple, designed to fulfil the above indications and obviate these defects, has recently been constructed under my directions, and has borne the test of use so well as to justify its continued regular employment (Fig. 5). The wire of which it is made passes back in a straight line to the top of the ear, at which point it is bent somewhat abruptly downward, and is made to conform accurately to the posterior surface of the conch close to its junction with the head, where it rests in contact with the ear, but without perceptible pressure. Asymmetry in the height of the ears, causing tilting of the frames from the level, is to be met by a compensating adjustment in the temples, *i. e.*, bending the temple upward on the side of the higher or downward on the side of the lower ear—or both—and so dividing the result between the two sides.

The glasses should be slightly inclined from the perpendicular, so as to bring the lower edges somewhat nearer the face than the upper, which is to be effected by giving the temples the appropriate angulation at their junction with the hinges when it is impracticable to change the direction of the hinges themselves.

The material of the frames should usually be gold of a good quality and of a weight as light as is consistent with strength and steadiness. Steel rusts too readily and is

not well adapted to the adjustments frequently required—more especially in the temples. Silver is so soft as to be almost worthless.

The lenses themselves should usually be as large as the face of the wearer permits: seldom less than 28x38 mm. for an adult, and not infrequently as large as 29x40 or 30x42 mm., in order that the eyes may be well covered in their ordinary lateral movements. Such large lenses are hardly more conspicuous than small ones—especially if frameless glasses be used—because they allow the eye itself to be easily seen. The reflections from the edges of frameless glasses which are so annoying to some persons may be avoided by slightly dulling the polish on the lower edge; the source of this reflected light being usually at or above the level of the eyes, the reflection enters the eye from this edge alone.

The glasses should be worn as close to the eyes as possible, without touching the lashes. Occasionally, where the lashes are especially long, with feathery or uneven ends, they should be neatly trimmed with the scissors—a little procedure best practiced when the eyes are closed. It is also to be borne in mind that the subject has an artistic aspect and that by giving proper consideration to this phase much can be done to remove the opprobrium which frequently attaches to the wearing of glasses. The neat adjustment of a pair of frameless gold-mounted spectacles is doubtless the best that can be accomplished with spectacles in this respect.

I have limited myself to a description of no one form of bridge, nor even of a number of special forms, but the effort has been made rather to demonstrate *the mechanical principles involved in the construction and adaptation of spectacle-frames suitable to all the requirements of practice.* By the means proposed it is practicable to secure the correct position of the glasses before the eyes, together with comfort to the wearer and a satisfactory artistic effect, thus fulfilling the three principal indications of spectacle-mounting.

FRENCH ANTISEPTIC ELIXIR.

Carbolic acid, crystallized	5 parts
Tincture of iodine	10 parts
Essence of citron	3 parts
Essence of mint	5 parts
Alcohol of 60°, sufficient to make . .	1,000 parts

UNUSUAL CASE OF PELVIC ABSCESS.

BY ALEXIS M. LÉON, M. D.,
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A collection of pus in the cavity of the pelvis may be the result of one or more distinct inflammatory processes. Primarily the cause may be (1) an injury, (2) a tubercular process, (3) a suppurative inflammation occurring in an ovarian tumor for hæmatocele, or (4) a puerperal infection.

Again, its seat may be (1) in the connective tissue of the broad ligaments, (2) in the general cellular tissue of the pelvis, or (3), as a result of peritonitis, it may be enwalled by peritoneum. A pyosalpinx might also be considered a form of pelvic abscess.

By far the most frequent form of the disease under consideration is a cellulitis of the broad ligaments due to puerperal infection. Authorities have not considered, however, that the variety or seat of the inflammation in the pelvis has much to do with the symptoms or course of the disease. The diagnosis, it is believed, can be easily made by the symptoms of septicemia and the physical signs of the existence of a tumor in the pelvis. The termination of the cases, if left to Nature and if the patient survive the septicemia, is said to be in the discharge of the abscess either (1) "through the abdominal walls and saphenous openings, (2) into the pelvic viscera, as the bladder, rectum, vagina or urethra, (3) through the floor of the pelvis near the anus, (4) through the pelvis foramina, either obturator or sacro-ischiatic, (5) through the pelvic roof into the peritoneal cavity or (6) into the lumbar region in the position of the kidney." (J. Braxton Hicks.)

This general view of pelvic abscess embraces both the common and unusual forms of the disease. The cases presenting, together with marked constitutional symptoms, a palpable abscess in the pelvis, which, in a short time discharges or is relieved by operation, are of comparatively frequent occurrence. But the cases wherein the diagnosis is difficult, and no tumor or swelling is discoverable by examination are rare. Yet, probably, both classes are produced under the same conditions, and are originally located in the same parts of the pelvis. The interest in these latter cases, therefore, lies in the fact that occasionally a collection of pus, due to any of the causes of pelvic ab-

scess, may reside in the pelvis and escape detection. And this fact does not seem to have been very generally stated.

The following case illustrates this difficulty in diagnosis. It is unique, also, in its chronicity, its spontaneous cure, in the uncertainty of its seat of origin and in the course or directions of the burrowing of the pus.

The patient, 29 years old, a native of Italy, married and the mother of four children, was a stout and strong woman, whose family history was good and who never remembered having been sick, with the exception of an attack of scarlatina some years before. Two years ago she had resided in a malarial district. Her last child was born April 8, 1888. Her labor was managed by a midwife, and is said to have been easy and natural. During the last months of her pregnancy, however, she had not felt perfectly well. She was languid, complained of headaches and had noticed slight puffiness about the face and ankles. After her labor all progressed favorably until the third day, when, it is said, fever set in. On April 16, eight days after the confinement, I saw the patient. At this time she complained of feverishness and loss of appetite; the bowels were loose; she was having two or three watery passages per day, and there was a profuse inodorous white discharge from the uterus. Temperature, 104°; pulse, 120; respiration, 30. She complained of no pain and there had been no vomiting.

Examination of the heart and lungs was negative, except that a few râles were heard at the bottom of the chest, posteriorly. The liver was not enlarged; the spleen was somewhat enlarged. Some tenderness was found, on deep pressure, over the fundus uteri and to the left of it. The uterus itself was subinvoluted and the cervix was lacerated. By conjoined manipulation, no particular tenderness and no tumor could be determined in the broad ligament or in any part of the pelvic cavity. The uterus was freely movable, and movement did not cause pain.

On the following day there was amelioration of the symptoms. Temperature, 102°; pulse, 110. The discharge still continued—profuse and inodorous, and the patient declared she felt no pain. During the three days following the improvement progressed. On April 20, examination showed the uterus to be much smaller in size. The tenderness had disappeared and the discharge had ceased abruptly. The fever continued, however, together with the diarrhœa. The movements from the bowels were large, watery and bad smelling. The temperature varied from 100½° to 101½° in the morning, from 102½° to 103½° in the evening, when profuse sweating would set in, often lasting through the whole night. Occasionally in the afternoons the patient would complain of chilly sensations; though no marked chill occurred. She now became emaciated and markedly anemic. Anorexia was complete; so that nourishment was given with difficulty. The urine was slightly albuminous and showed a few granular casts and renal epithelia under the microscope. This condition of the patient persisted during the next three weeks with but little change. The temperature gradually sank; so that by the end of this time it did not rise above 100° in the morning, or above 101° in the evening, and was sometimes lower; and the pulse-rate fell correspondingly. Antipyretics, it may be stated, had little or no effect, however. The sweatings, too, became less frequent and of milder character. Digital examination showed the uterus to be of normal size and in proper position, freely movable and its movements free from pain. No tumor could be found in the pelvis, and no tenderness was elicited by bimanual touch. The result of rectal examination with the finger was also negative.

By May 15, the albumin and casts disappeared from the urine and the morning temperature fell as low as 99°. The patient made efforts to sit up, but was unable to remain out of bed. Under treatment the anemia became less marked and the appetite began to return; so that occasionally she could eat a little solid food. She did not gain strength, however.

About May 23 she called attention to a stiffness and pain in the left groin. This was occasioned by straightening out the leg. There was no swelling or redness about the parts and no tenderness either about the abdomen or leg. The thigh was kept partially flexed and rotated inwards, and the pain made it impossible to fully extend the leg. When standing or attempting to walk, the pelvis would be tilted to one side and only the toes of the left foot would touch the ground. The amount of pain and stiffness and the flexure of the thigh varied from day to day. On June 5, careful examination (which had been employed daily since the appearance of the symptoms about the leg) revealed some fulness in the left

lumbar region, but no fluctuation. Deep pressure over this spot caused some pain. This swelling increased during the next four or five days and could readily be mapped out—about four inches in diameter, not projecting far outwards and causing no discoloration of the skin.

It was proposed to introduce an aspirator needle, and if pus were withdrawn to cut down upon the needle and drain the abscess. The patient would not consent to any surgical procedure and even refused to be aspirated. On this account the case was out of observation from the 11th to the 25th of June. On this day the patient's general condition was found to be about as before. The swelling in the back had increased somewhat, and external to the quadratus lumborum. The skin was red and the tissues hardened and infiltrated. This redness extended slowly forwards from day to day along the abdominal wall, in a line parallel to the crest of the ilium, until the groin was reached. The skin here became thin and on July 3 opened, giving vent to about one quart of thick yellow pus, which continued to flow in large quantities for several days. Again the patient refused surgical aid and would not allow even probing of the sinus. At this time her fever disappeared, her diarrhœa stopped, her appetite returned and the flexure of the thigh began to grow less and less. The abscess continued to discharge for three or four weeks. From its situation it drained itself, and so was completely cured in that time. The patient grew strong and well and the flexure of the limb, after a while, entirely disappeared, allowing the patient to stand perfectly straight and to walk without difficulty. On June 25, 1889, she was delivered of a healthy child, after a normal labor.

It will be observed in reviewing this case, that distinct signs of pelvic inflammation occurred at no time except during the first few days, when the discharge from the uterus was present, and the signs were, then, more of endometritis than of cellulitis; that the abscess was probably in existence six weeks without presenting any local signs, such as pain, tenderness, swelling etc., and at the end of this time the only sign was the flexure of the thigh and the pain on effort of extension; that it was two weeks longer before the fulness in the lumbar region occurred, and two weeks longer still before the skin showed positive evidence of the inflammatory process beneath it; and that it was nearly three months in all before the abscess was discharged. These general features may explain why the diagnosis was not made positive until the appearances in the loin presented themselves. Previous to this time the picture was one of continued fever with diarrhœa, and more or less septic infection; and it was recognized that such condition might be produced by typhoid fever, acute miliary tuberculosis, or an abscess causing pyemia.

It should be stated that this patient was several times examined by different consultants, without their being able to locate any lesion in the pelvis, notwithstanding the fact that attention was directed at first to the pelvis as the seat of the disease and repeated efforts were made to find an abscess whose existence was suspected. The question of the exact location of the primary abscess is, on this account, not settled with certainty. It is likely, however, that its seat was in the left broad ligament. Its small size in the beginning, together with the fact that its contents, were drained through the uterus, would explain why no tumor could be appreciated. And there must have occurred early in the history of the case adhesions between the abscess and the posterior wall of the pelvis as high up as the brim, and perhaps higher. In this manner the tumor, as it grew in size, was pulled further and further out of reach by any ordinary examination; though it is possible that examination by the introduction of the hand into the rectum might have given some idea of its existence. It is conjectured, therefore, that the abscess began in or near the fimbriated end of the Fallopian tube—since, in this location, it could discharge through the tube (as it seemed to do at first) and, being movable, could form adhesions posteriorly.

Cases similiar to this one are reported by Dr. Skene, in his text book of *Diseases of Women*, and reference to them may supply the actual appearances presented by dissection. Dr. Skene relates these as cases of "pelvic cellulitis, with certain complications which, so far as I know, have not been noticed or described heretofore." The first patient, 37 years old, and the mother of six children, got up the fifth day after confinement, and was taken sick on the ninth day. She was in bed, but without medical attendance for six weeks, when she was seen by a physician who found all the signs of pelvic cellulitis of the left broad ligament and symptoms of septicemia. Four weeks later

she was admitted to the hospital for operation. She was then in a very enfeebled condition, her temperature varied from 100° to 103°, and there was flexure of the left thigh. The abdominal symptoms had subsided. Laparotomy was done by Dr. Skene, "and a most careful exploration of the pelvis was made by the touch. The left broad ligament was considerably thickened and much less elastic than it should have been, showing the effect of the inflammation, which had subsided. Not the slightest sign of any point of suppuration could be found, but by the bimanual touch, with the fingers of one hand in the abdominal cavity and those of the other on the outside, I detected obscure fluctuation, indicating that an abscess or sinus extended along that side of the abdomen. The location of the pus having been clearly marked, the wound in the abdomen was closed and an incision made in the side down to the pus." The cavity, which was narrow at its lowest end, was found to extend to the diaphgram. It was washed out and a drainage-tube was introduced. The patient passed out of observation one month after the operation; at which time the wound was still discharging pus.

The second patient, 35 years old, gave a history of illness (fever) from the day of the birth of her fifth child. She was seen four months after confinement, when symptoms of septicemia were present, and there was also flexure of the right thigh. The uterus was apparently normal and movable, but high up and on the right there were evidences of inflammatory products. Explorations with the aspirator failed to discover pus. Laparotomy was performed, and pus was found in the right iliac and lumbar regions. The patient died three days later. "The autopsy showed that the abscess cavity extended from the right broad ligament upward behind the kidney and to the right of the spinal column to the diaphragm. The psoas muscle was involved in the abscess, but there was no bone disease, and it was the opinion of all who attended the autopsy that the disease began as a cellulitis of the right broad ligament."

These cases resemble the one I have the privilege of reporting in the following points. All began (probably) as a localized cellulitis of one broad ligament; sooner or later adhesions were formed between the abscess and the posterior pelvic wall; and the pus, then, tended to burrow towards the surface through and between the muscles. The track thus made by the burrowing pus, it will be noted, tended to close up and heal as the sinus advanced; so that, by the time the site of the abscess was upon the psoas muscle, the suppuration in the broad ligament had ceased.

These cases are certainly rare (I have not found any others reported), and the lesson of special interest they teach is, that a pelvic inflammation may result in an abscess, which, even early, may occupy a position out of reach by any ordinary examination; and such a condition may be difficult of diagnosis.

DOUBLE OPTIC NEURITIS OF MALARIAL ORIGIN.[1]

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January 12, 1888, Mrs. F. K. W., fifty-five years old, consulted Dr. C. W. Packard, of New York, on account of failing vision. The patient was referred to me. She complained of a blur in the upper field. Upon examination I found moderate peripheric impairment of the field in the left eye. Right vision=$\frac{20}{15}$ W.+.75. Left vision, $\frac{20}{20}$+W. +1.0. Ophthalmoscopic examination negative.

January 13. The following morning the patient was led to my office by a daughter. R. V.=5 fingers; L. V.=perception of light. She had retired the preceding evening, seeing as well as when at my office in the morning, and awakened practically blind. Right field with candle, quick and good. Ophthalmoscope showed marked papillitis, œdema of the disc, evident infiltration in and near the optic nerve, veins slightly enlarged, no pulsation, arteries about normal, outline of disc somewhat obscure, slight tortuosity of veins, no retinal changes apparent. Approximate swelling of 3½ dioptrics of nerve.

Thinking the case of unusual interest, I took the patient to Drs. Agnew and Webster. They corroborated my diagnosis and expressed surprise at the rapidity of loss of vision.

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[1] Read before the New York State Medical Society, February 3, 1891.

January 18. Perception of light in each eye. January 22. V.=nil.

January 30. Sixteen days from beginning neuritis, complains of stiffness in knees. Has more or less difficulty in walking. When reclining, finds it impossible to turn over. This affection of the joints came on suddenly and in four days the patient could not rise from a chair without assistance. By being supported she could shuffle along the floor. On striking her quickly under the hip, the limb would fly up, and by this action she could ascend stairs. There was complete paraplegia. Exaggerated reflex, ankle clonus. In fact, she lost all locomotive power of the lower extremities. The skin felt thick and numb. Bladder unaffected.

February 5. Patient for the first time in fourteen days has perception of light. Has enough control of her limbs to enable her to move about with the aid of a chair.

February 22. Vision improving. R. V.= 10 fingers. L. V.=5 fingers. Color perception lost as far as could be ascertained. Six days later can distinguish bright red. Field good, retinal vessels slightly diminished in size.

March 7, 1889, thirty-nine days from beginning paraplegia, is able to walk. R. V.= $\frac{20}{200}$; L. V.=$\frac{4}{200}$. Field good, color sense diminished. Nerves pale, otherwise the fundi are normal, with the exception of slight decrease in caliber of arteries.

April 7, 1889. R. V.=$\frac{20}{40}$; L. V.=$\frac{20}{100}$. Color sense varies; calls red brown. Left nerve whiter than right.

April 17, 1889. Stiffness in knees entirely gone. Color perception impaired.

February 14, 1890, two years from initial papillitis, R. V.=$\frac{20}{15}$W.+.5 L. V.= $\frac{20}{20}$+W.+.5, which is a return to the original vision before the neuritis. Color sense decidedly impaired.

December 29, 1890, last examination and nearly three years from beginning neuritis, R. V. =$\frac{20}{15}$W.+.75; L. V.=$\frac{20}{20}$+W. +1.0. Ophthalmoscopical appearance: Rt. =nerve bluish white, veins normal, arteries slightly diminished; no tortuosity; lamina cribrosa plainly visible. Left=nerve bluish white, otherwise the fundus has a normal appearance. Color sense: pale yellow, green, or pink, looks drab; cannot distinguish green from blue. Right eye=the field for yellow is very much contracted. A little less for red, and less than normal for blue. Left eye=yellow visible in central vision only. Red, field tortuous in outline and very much diminished. Blue, contracted much less than in right, with a large scotoma in upper field. Field for white perfect in each.

The patient received a nutritious diet, iodide of potash, arsenic and strychnia.

During the entire illness, the patient was free from pain, slept well, appetite good, no nausea, no headache. The urine was examined several times, with negative results. No specific history. She has had eight children, all healthy, no miscarriages. Passed the climacteric at forty-two years. Mrs. W. has been a decidedly healthy woman, with one exception, and that exception is best expressed by the following extract from a letter written by Dr. Packard: "So far as I know, Mrs. W. has no specific taint, but she has a decided malarial taint. I have treated her during the past few years for several malarial attacks, accompanied with fever, characterized by periodicity, and that yielded to quinine. At such time she has suffered from gastralgia and enteralgia that I believed to have a malarial basis."

Résumé.—An apparently healthy woman consults an oculist because of a slight blur in her vision. He finds both fundi normal, pupils slightly dilated and responsive to light. During the same night she becomes practically blind. The only apparent cause is a marked papillitis. This continues to be an idiopathic affection for sixteen days, then she has a paraplegia. The vision becomes totally lost. In fourteen days, upon a relaxation of the paraplegic symptoms, the sight gradually returns; and in two years is normal, with a decided defect in color vision.

Was the neuritis an idiopathic affection, or was it concomitant to the paraplegia, and what was the existing cause of both?

Optic neuritis is often accompanied with headache, nausea and vomiting; and it usually occurs from some intra-cranial disease, tumor or other adventitious product.

With tumor the progress is inclined to be slow and the prognosis grave. To be brief, let us exclude tumor as a cause, also meningitis and sclerosis and Bright's, for palpable reasons.

Retro-bulbar neuritis (von Græfe).—A condition in which we may have a sudden loss of vision. The pupil is usually widely dilated and not responsive to light. The disc becomes slightly elevated. Arteries small, veins tortuous.

"In retro-bulbar neuritis in the acute form, we have headache, orbital pain, in-

creased by movement of the eye and pressure. Serous effusion of the optic disc and retina due to compression of retinal vessels." (Knapp.)

In Noyes's admirable treatise on the eye (1890) he describes a toxic retro-bulbar neuritis, where the atrophy succeeding the inflammation is due to a lesion of the axial fibers of the nerve, and cites a case of Uhthoff's, where he localizes the character of the lesion in color scotoma. If there is a retro-bulbar neuritis due to tobacco and alcohol poisoning, why may there not be a similar affection due to malarial poisoning?

There are certain affections due to the action of malarial poison upon the system. There is a *bacillus malariæ* particularly affecting the spleen. This bacillus has been found in the blood during the fever, causing marked changes in it.

Let us turn our attention to another cause of papillitis, denied by some, *i. e.*, distention of the sheath, or hydropsia of the optic nerve, which is a serous effusion into the optic sheath coming from the cerebral arachnoid space.

"A fluid effusion into the arachnoid space and increased intra-cranial pressure are always associated with an accumulation of fluid in the intra-vaginal sheath, which œdema will cause a swelling of the optic nerve." (Schwalbe.)

"The intra-cranial pressure must force the fluid from the arachnoid space along the sheath of the optic nerve into the canal-like system present in the lamina cribrosa, causing swelling and congestion of the disc." (Pagenstecher.)

Bull says, loss of vision from isolated papillitis alone is never sudden, and that distention of the sheath alone is not sufficient to produce papillitis, but may intensify it. Hughlings Jackson is of the same opinion, and the latter also says there is nearly always a visible stage of neuritis before sight fails.

Macnamara, in his text-book of disease of the eye, cites a case precisely similar in many respects to the one in question. A girl, aged thirteen, was attacked with intermittent fever, after which she had paralysis of the lower extremities, and a partial inability to move the right arm. Pupils dilated and insensible to light. Optic papillæ swollen and hazy, with serous effusion into the nerve and surrounding tissue. She became quite blind. Her recovery was gradual and perfect, both as to the paraplegia and vision. He remarks that this is an example of a class of cases not very uncommon in India, and depends upon malarial poison affecting alterations in the blood. He gave, as a direct cause, a serous effusion into the optic thalami and corpora striata. The pressure thus exerted on these nerve centres, interfering with the volition of the patient over the affected limbs, and the serous effusion or exudation into the papilla and pressure upon the optic nerve fibers causing the loss of vision.

I offer this paper as a contribution to the literature on optic neuritis. I am aware there may be double optic neuritis with and without loss of vision, also with gradual or sudden loss of vision. But, as a rule, there is a stage of neuritis visible before the blindness. Here the fundi were known to be normal a few hours before an almost total loss of sight.

101 Park Avenue.

ADHESION OF SOFT PALATE TO PHARYNX; OPERATION; CURE.[1]

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The patient, a man 40 years old, by occupation a seaman, and a native of France, applied to me November, 1889, complaining of shortness of breath. He wanted to know if anything could be done to restore his speech. He was able to utter a sound, but he could not turn this sound into words.

He had contracted syphilis twenty years before. He was married, and his wife had miscarried three times. One child was born living, and is now twelve years of age, and apparently in fair health. This communication was made on paper, as the patient was unable to talk. His nose was entirely eaten away down to the nasal bones, so that all that remained was a small opening in the face. The nasal fossæ would fill up with large green crusts, which he dislodged with a hair-pin every morning and evening. The stench from these crusts was exceedingly offensive. I took out two, which were fully ten and a half inches in length, and shell-like in form. The patient's mouth was so

[1] Read before the Medical Society of the Missouri Valley, December, 1890.

closed up by syphilitic adhesions that I could pass in my two fingers only with great difficulty, by stretching the mouth to its utmost capacity. A laryngoscopic view of the throat at this stage was impossible.

The first operation I undertook was enlargement of the mouth, which was done by means of a knife. Afterwards little wooden stretchers or gags were inserted, to prevent the wounded surfaces from growing together again. After this was accomplished, I found that the uvula and the lower part of the soft palate were entirely destroyed, and the remaining part of the palate was firmly adherent to the pharynx, so that the upper pharynx was completely separate from the lower pharynx. The complete occlusion of the two pharynges is extremely rare. I have met with it in only three cases. It is by no means rare in tertiary syphilis of the throat to find a partial adhesion of the parts; but it is extremely rare to find a complete adhesion. Often a small opening can be discovered, sometimes only large enough to admit a small probe, but still large enough to admit a small current of air.

In this case I covered the lower pharynx with iodoform and filled the nasal fossæ with water. My iodoform was not moistened.

I now determined to liberate the palate from the pharynx, so that I could give my patient nasal breathing, and also give the nasal cavity an outlet into the throat. I first passed a silver probe down through the nose to the pharynx, and with a tenotomy knife cut where the palate bellied. After I had thoroughly separated the palate from its attachment, with no little difficulty, the parts were sprayed with a solution of tannin. No anæsthetic of any kind was used. I now began to pass the largest sound I could obtain through the opening into the pharynx. I afterwards had a sound made after the following description. The body of the instrument was about two inches in length, and it was blunt-pointed at the end, and gradually as it reached the base, it was somewhat similar to a triangle in shape. The base was an inch and a half in width. To the broad end of the instrument was attached a long handle, so that it could be manipulated in the throat. I found that with this instrument I could keep the opening the required size and prevent it from closing. Had the wound not been treated with sounds after cutting, the opening would have filled up in a very short time.

This is a peculiar characteristic of syphilitic tissue, where we seek to enlarge an opening, whether it be in the pharynx or nasal fossæ. In a case of nasal stenosis now under observation, I have seen the parts close completely after opening the nasal canal three times, every time giving the patient complete breathing space, taking out at each operation a large piece of cartilage at the point of union. In a short time the parts were firmly adherent again.

The parts in this operation healed nicely, and within four days absolutely no pain was felt from the passage of the instrument. An examination of the larynx showed complete paralysis of the abductors of the vocal cords, and the whole mucous membrane lining the larynx was in a state of hyperemia. This accounted for the loss of voice. At the beginning of my operations, I had placed my patient under iodide of potassium; but I was compelled to give him 90 grains, three times a day, before I could produce any effect. I do not consider this an unusually large dose in cases of tertiary syphilis of the throat and nose, and have often given larger doses and maintained them during a longer time. This was given in Vichy water; his stomach stood it nicely, and I kept this amount up for two weeks, when it was gradually reduced. Later I gave him only tonic doses. Within a month and a half from the time of the first operation on the mouth, the patient had entirely regained his voice, and had gained something like fifteen pounds in weight. His voice was now quite clear and strong. I had an artificial nose made for him by Tiemann & Co., while I was attending the Manhattan Throat Hospital of New York last August, which supplied his missing member very well. I gave him one of the sounds above described, and told him to use it once or twice a week for a year. I often hear from him, and he reports the breathing through his artificial member excellent, and his voice good.

SYPHILIS FROM A BITE.—A patient was recently shown to the Berlin Medical Society with syphilis from the bite of a man. The bite was on the lip. The wound healed in two or three days; but in six weeks it reopened and the lip became greatly swollen. Five weeks later there was an ulcer on the inner surface of the lip with great swelling and induration round about; the submaxillary and cervical glands were much enlarged. After some time a typical syphilitic eruption made its appearance.

PERISCOPE.

Some New Medicinal Soaps.

In its Periscope of Dermatology, the *Edinburgh Medical Journal*, February, 1891, says: Eichhoff of Elberfield, who has already added to the list of medicinal soaps some of real value, and embodying some valuable improvements, has continued his researches into the subject. He reviews the conditions of the skin in which soap treatment is to be recommended. This is specially indicated in cases where the skin is unctuous. The soap removes the excess of fat, while the incorporated drug, if suitably chosen, acts at the same time on the disease itself, and, as Eichhoff thinks, can chase the offending organisms from the ducts of the cutaneous glands. He quotes in support of this the treatment by medicinal soaps of psoriasis, which he regards as parasitic, and of acne, the pustules in which are now believed to be due to the pyogenic micrococci. He praises also the cleanliness, the innocuousness, and the cheapness of this method with the vigor of a true partisan.

Soaps may be, for convenience, divided into—1. Alkaline, containing an excess of free alkali; 2. Neutral, in which all the alkali is combined with the fatty acids; 3. So-called acid soaps, which are prepared either by the addition of weak acids, or by being superfatted, and eventually react faintly acid. The alkaline may be used to remove masses of scales; while in acute inflammations of the skin, or when it is irritable, the neutral or superfatted soaps are to be employed. The superfatting of the new soaps consists of 2 per cent. lanoline and 3 per cent. olive oil, and they are made by Ferdinand Mühlens at Cologne. Among these new soaps may be specially mentioned a *menthol soap*, containing 5 per cent. of menthol. The local anæsthetic influence of menthol on the skin is well known, and the principal use of this soap will probably be found in lessening pruritus. Eichhoff cites some cases where cure resulted in pruritus senilis and pruritus genitalium. He recommends that, should the soap be employed for the head or face, the eyes should be kept firmly shut, else an unpleasant, though, he says, not dangerous, coldness of the conjunctiva is perceived. A 5 per cent. *salol* soap is one which may prove useful in psoriasis. The salol when so used with water breaks up into carbolic and salicylic acids, and these in their nascent condition may be expected to act with energy. A 5 per cent. *resorcin* soap promises to be of advantage in cases where this valuable drug is indicated.

Ligation of the Saphena Vein in Cases of Varicose Veins.

The *British Medical Journal* (Supplement), January 24, 1891, says: Professor Trendelenburg, of Bonn, in a contribution to the last number of the *Beiträge zur klinischen Chirurgie*, advocates double ligature and division of the large saphena vein in the treatment of varicosity of the lower limb involving both the trunk and branches of this vessel. In some remarks on the pathological anatomy of varicose veins it is pointed out that the most prominent and dilated portions of the affected vessel are found below, and not, as is generally supposed, (? REPORTER) above the valves. The walls of the vein, being weaker here than at any other point, yield to the pressure of the blood when the valves cease to act. According to Trendelenburg, most of the blood which fills the dilated trunk and branches of a varicose saphena vein is derived from above, and has descended from the iliac veins and the vena cava, and but a small portion of it comes from the capillaries of the foot and leg. When the subject of varicose veins exchanges the horizontal for the vertical position a large quantity of blood at once descends from the large veins of the abdomen into the dilated veins of the lower extremity. It is this free downward flow of blood along large and dilated vessels deprived of valves that causes the profuse and dangerous hemorrhage so frequently produced by a breach of the surface of the leg when in a condition of varicosity. The conclusion that the troubles and dangers of those suffering from varicose veins of the lower limb are due for the most part to the fact that the varicose branches of the great saphena, in consequence of associated dilatation of the trunk of this vein, are no longer separated from the vena cava by valves, has led Trendelenburg to treat varicosity by permanently obstructing the saphenous trunk at one point with the view of preventing the descent of blood from the abdomen, and thus relieving the veins of the leg and foot from the abnormal pressure. After obstruction of the flow of blood through the main trunk of

the great saphena, the venous circulation will be maintained by communicating branches between the superficial and deep veins. Reference is made to a series of cases in which good results followed such treatment, which consists in exposure of the vein near the saphenous opening, in the application of two catgut ligatures, and in the division of the vessel between them. It is acknowledged in this paper that occlusion of the great saphena is by no means a novel plan of treatment in cases of varicosity of the lower extremity. It was practiced by Paulus Ægineta, and advocated by Ambroise Paré, and at the end of the last century Sir Everard Home performed this operation on twelve cases with very unfavorable results.

Vaccination of Children.

Dr. E. F. Brush, in a paper on Infant Hygiene, read before the Jenkins Medical Association and published in the *Archives of Pediatrics*, February, 1891, makes some pertinent remarks on the subject of vaccination, saying that this important hygienic measure, if physicians are not more careful in regard to the operation, is liable to be brought into disrepute. In 1883, while Dr. Brush was occupying the position of attendant physician to the New York Infant Asylum, he examined the arms of one hundred and ninety-one children who had been vaccinated and deemed sufficiently protected. Of these he found only thirteen with a well-defined, pitted scar; only one had two well-defined, round and pitted scars; fifty-one had no scars at all, although they had been vaccinated; the remainder had scars in various forms, shapes and colors; no vaccination had been performed for three months previous to the examination; nevertheless, some of the arms were still crusted. The majority of the older scars contained cicatrices, long, irregular, varying in dimensions from one inch to two inches; some had purple ridges in the centre, some red, others had cavities blue and red with puckering edges. Many of these children were vaccinated sucessfully, showing that, notwithstanding the severe and destructive processes that had previously taken place in the arm, they were not protected. A baby should be vaccinated at four months old, unless it is necessary to do so earlier. Physicians should see the child on the fourth and eighth day after the operation, and satisfy themselves that there is a proper formation of a vaccine vesicle. Vaccinations are constantly seen that are reported to have taken because sores have been generated by the operation which in no way simulate the vaccine vesicle.

It is preferable to vaccinate a child at four months, because this is usually before dentition takes place. In regard to dentition, it is an exceedingly dangerous thing for the physician to teach the mother that any severe attack of illness is due to teething, for she is very apt to delay the physician's attendance on her child that is ill during the dentition period. Dentition, *per se*, is not the cause of any severe attack of illness. The most severe condition due to teething alone is a slight ephemeral fever, a cough or an eruption, not in any way making the child ill enough to require medical attention. Of course, the irritation that is sometimes caused in the gums will make more severe a disease due to some other cause, and the child, during dentition, that is at all affected by this normal process, is more apt to be attacked by the prevailing diseases.

Washing in Cold Weather.

The *Nightingale*, February 14, 1891, says: If your face chaps easily and is uncomfortable in cold weather, try the following: Get a fine quality of Indian meal. Take a handful of this meal and pour boiling water over it. Then add enough cold water to reduce the whole to a bearable temperature. Take into your two hands some of the dry meal, wet this in the water as prepared and scour the face with it, using it upon the hands as you would use the lather of soap. Finally, rinse the face in the specially prepared hot water and dry. Use the towel, sparingly, so that the face may dry partly by evaporation. If afterwards you pass the hand over the face you will be surprised at the smooth comfortable feel which has been given to your irritable skin. You will also find it less sensitive to the wind and cold.

What is accomplished by this process? In the first place the skin is thoroughly cleansed by the handful of uncooked meal, the little particles of which scour out the sebaceous ducts as no amount of soap can do. It is almost impossible to cultivate a crop of black-heads and adhere to this treatment. In the second place the meal over

which the boiling water was poured has been partly cooked so that a soupy consistency is given to the water in which your face is bathed. This dries in a film over the skin, protecting cracks and rendering it much less likely to catch dust. Try this method of taking care of your skin. It is not at the time so enjoyable and does not seem so clean as the old soap and water method, but the results are far superior.

Multiple Herpes Zoster.

In a Clinic Report in the *Medical Chronicle*, February, 1891, Dr. James Mackenzie, of Victoria Hospital, Manchester, says: On account of the rarity of such cases the following appears worth recording.

Mrs. L., aged 51 years, a widow lady in comfortable circumstances, tall and of full habit of body, had been attending four days at a bazaar, when, at times, from over-crowding, the atmosphere was very impure. Previous to this she had been in good health. The second morning, after attendance at the bazaar, she felt intense smarting pain in the right armpit. On looking there she observed a few small blisters. A few hours later a similar pain was felt in the left armpit, and there also a few blisters appeared. During the night and next day there was severe pain shooting down the inner side of both arms, as low as the elbow. Occasionally a feeling of numbness and pain extended down the ulnar half of the left forearm, and to the two inner fingers. Pain also appeared to shoot down the chest, as low as the level of the nipple. There was also pain in the throat and in the nose. Shooting, burning pains were also felt on the inside of the thighs, and small blisters appeared on both thighs and on the nates.

I examined her on October 19, 1889, four days after the beginning of the complaint. In addition to the sensations which she voluntarily described, I found pain and tenderness along the whole spinal column, much aggravated by the slightest pressure on the separate vertebræ. This was worst over the two lowest cervical and upper two dorsal vertebræ. In each armpit there was a large patch of vesicles occupying the hollow of the armpit, about three inches in diameter. On the right side there was a thin irregular streak of papules descending on the side of the chest as low as the level of the nipple. Two days after, these had developed into small vesicles full of clear transparent fluid. On the edge of the posterior fold of the axilla and descending for a few inches towards the inside of the arm was another streak of papules that likewise in a couple of days developed into a crop of vesicles.

On the inner aspect of each thigh, about six inches below the pubes, there was an irregular oval patch of vesicles. The patch on the right thigh measured two inches by one, while that of the left was somewhat smaller. The patches occupied similar positions on each thigh. To the inside of the right fold of the buttock, two inches from the middle line and midway between anus and vagina, was a small irregular red patch, but no papules nor vesicles. She complained of the same peculiar pain here as occurred in the armpit, arm and thigh. She also felt the same pain in the identical spot on the opposite side, but was extremely surprised when I said there was no eruption.

There were also two raw sores about the size of a split pea on either side of the septum of the nose, about an inch from the external opening of the nostril. She said that these had been small blisters, and the pain had been so annoying that she had burst them in the hope of getting relief. The fauces were sore, and looked red in patches, but there were no vesicles.

The illness pursued a very severe and painful course for the next two months. Every few days there would be recurrence of the pain, causing sleepless nights. The situation of the pain was most frequently down the inner half of the left arm, forearm, hand, and two fingers (little and ring fingers). Less frequently and less severely the pain would strike down the same places on the right arm. Occasionally the pain occurred in the face, generally in the cheeks, both at once and on identical places, and also on the inner side of the upper part of the thighs and upper part of the chest. On all those places there developed, after an attack of the pain, an eruption, sometimes limited to one or two papules, some of which developed into vesicles—sometimes a crop of vesicles covering an area the size of a florin, sometimes a streak extending to one or two inches in length.

These attacks gradually diminished in intensity, and she was progressing favorably when, on the 4th of April, 1890, she had a severe attack of pain in the face, followed by an eruption of vesicles situated on both upper eyelids, around both nostrils, and on

both sides of the lower lip. After this attack subsided she had no recurrence of any of the previous severe attacks, but during the next six months, after any occasion when she had any mental bother or worry, she would feel on both cheeks the same peculiar stinging pain, which would continue from five to nine hours and terminate with the eruption of one or two papules. These would either remain stationary for a day or two and disappear, or develop into vesicles. She reckoned there would be at least twelve such attacks, and they ceased exactly twelve months from the onset.

During the attacks of pain affecting the left hand, arm, and, in a less degree, the right also, she complained of the loss of power in her hand and arms, so much so that she felt unable to knit or sew. I could never satisfy myself of any distinct paresis.

Kola Nut of Africa.

Mr. P. L. Simmonds, in the *American Journal of Pharmacy*, December, 1890, gives the following interesting account of the kola nut, which is now attracting so much attention.

This seed or fruit, known under a variety of names in different parts of Africa, as kola, gourou, ombéné, nangoné, kokkorokon and matrassa, has only within a few years come into important notice as a food stimulant. Twenty or thirty years ago, it was incidentally described by Dr. Daniel and Prof. Attfield, in the *Pharmaceutical Journal*, but its extensive employment in Africa was comparatively little known. Although its use as a stimulant, in the place of coffee, tea, maté and coca by other people, had been very general, almost from time immemorial among the various tribes of Equatorial Africa, the product was little known in Europe.

The opening up of Central Africa and the increase of trade on the West Coast has demonstrated its importance as a local article of commerce, and its chemical advantages have become duly appreciated. There are, however, two distinct products; one, the true kola nut, the product of *Sterculia acuminata*, popularly known as the female kola, and the false, or bitter kola, designated as the male kola. The true kola tree grows spontaneously over the range of Western Africa comprised between the 10° of N. latitude to the 5° S. latitude. This tree, to which attention has of late years been prominently directed by the authorities of Kew, has been introduced from time to time into India, Ceylon, Seychelles, Mauritius and Cochin China in the East; Zanzibar and Sidney, and in French Guiana, British Guiana, Guadaloupe, Dominica and Jamaica in the Western Hemisphere.

Incidental mention of this nut has been already made in this Journal—1880, pp. 6 and 7; 1883, p. 27; 1884, p. 166, and 1886, p. 391. The tree commences to bear at 4 or 5 years, but it is not until 10 years that it is in full fruit, when it will produce on the average 120 pounds of seed twice yearly. Flowering in June, the pods will ripen in October and November, and a second crop will be yielded in May and June following, The fruits as they ripen have a yellowish-brown color, and, as the central suture opens, exposes both red and white seeds. The women remove the seeds, which are most appreciated and valued when they are fresh and moist. To preserve them, they are placed in baskets, in layers, with the leaves of *Sterculia cordifolia*, which are kept damp. If they are kept, or to be transported any distance, the nuts are washed and fresh moistened leaves added every month. The packages, weighing about 1 cwt., are sent to the Gambia, Gone and other districts. When the nuts become dry, they are reduced to powder, and taken in this state by the caravans to the interior. They frequently arrive, however, in a fresh state at Sokoto and Kouka, in the Soudan, and at Timbuctoo.

Not only are the kola nuts consumed in Africa, but they are also exported to Brazil for the use of the negroes there. The seeds of *Sterculia Chica* and *S. lasiantha* are also eaten in Brazil.

Sierra Leone is the principal market for these nuts. Ten years ago, about 750,000 pounds of kola nuts were imported there, and 600,000 pounds to the Gambia.

The unerring instinct of man, even in uncivilized countries, has led him to select, from the many thousands of plants presented to him in Nature, just four or five, which, from their alkaloid active principle, theine, seem to be a necessary rather than a luxury of life. These nuts contain more theine (viz., 2.34) than most of the other dietetic products in use. The properties of the nut are said to be two-fold. In the first place, it enhances to many palates the flavor of food eaten afterwards; secondly, it possesses the

more important function of staying the cravings of hunger, and enabling those indulging in it to endure prolonged labor without fatigue. Being bitter, they are used as a stomachic and a tonic.

It is beneficial in periodical and chronic headaches, in heart complaints and diarrhœa; and, mixed with cocoa, it has been found a sustaining and stimulating adjunct in exhaustive and wasting diseases. It is said to clarify beer and spirits, and, like the clearing nut (*Strychnos potatorum*), to render drinkable foul water. It is even spoken of as a cure for drunkenness, from the amount of theine it contains. Probably other species of kola or sterculia may furnish seeds equally used if they contain caffeine.

The false kola nut has been named *Garcinia Kola* by Dr. Heckel, but is not yet well defined, although it resembles the Eastern *Garcinia Morella*. These seeds are employed like the true kola nuts, although they have not the same properties, being destitute of the alkaloid. They are contained in a large berry, like an apple, to the number of three or four; oval, cuneiform. They are chewed generally on the West Coast, and have a bitter flavor, like green coffee. They are said to be an effectual remedy for cold in the head, a few seeds being chewed in the course of the day.

Contagious Diseases Act.

The effect of the Contagious Diseases Act in England has been a subject of much discussion at different times. The latest on the subject is in the *Lancet*, February 14, 1891, where it is stated that, for the purposes of comparing stations under the Acts with those not under them, fourteen of the latter were selected by Surgeon-General Lawson, in a recent paper, for comparison, and were called "fourteen stations never under the Acts." Besides these two sets of stations was a third, designated "all the stations never under the Acts." In 1860, at the fourteen stations which came under the Acts in 1864 and subsequently, the ratio of primary sores was 146; at the fourteen unsubjected stations 134, and at all the stations never under the Acts 131. From these points all fell, so that in 1862 they stood at 117, 103 and 99 respectively. In 1863 the admissions at the fourteen unsubjected stations rose to 117, while those at the fourteen subjected were 107, and all the unsubjected 108. The compulsory examination began to take effect in 1867, and though there was an increase of the incidence of the disease on the country as indicated by rises in the ratio of 17 per 1,000 in both the fourteen and whole unsubjected districts, that at the fourteen stations under the Acts was 4 per 1,000 only; and from this year the ratios at the fourteen subjected stations were always much under those in the whole until 1884, the last year of the comparison. In 1871 the incidence of the disease on the country seemed at its lowest, being 93 for the fourteen unsubjected stations, 81 for all the subjected and 51 only for the fourteen subjected. The stoppage of pay showed its effects in 1874 by a fall at each class of stations, which was continued in 1875, and still traceable up to 1877, after which the advance of another epidemic wave caused a rise at the fourteen unsubjected stations of 40 per 1,000, at all the unsubjected of 20, while at the fourteen subjected it was 4 only. In 1879 there was a slight reduction of the ratio at both classes of unsubjected stations, but a rise of about the same amount at the fourteen subjected; but in 1880, with the cessation of stoppage of pay, there was a general rise, amounting to 39 at the fourteen unsubjected stations, to 37 on the whole unsubjected and to 27 at the fourteen subjected stations; a portion of this was no doubt due to an increasing incidence of the disease over the country, but a large portion also to the removal of the inducement to conceal primary forms of the disease by stoppage of pay. The beneficial effects of the Acts will be seen by the following figures. In 1860 to 1863, when no Acts were in force, the ratio of primary sores at the stations subsequently protected by them was 129.8. In 1870 to 1873, the Acts being then enforced in all, it fell to 52.5. Secondary syphilis fell from 39.9 to 20.2; gonorrhœa from 134.6 to 100.3. At all the stations never under the Acts the fall in primary sores was from 116.3 to 86.0, in secondary disease from 30.5 to 27.4 and in gonorrhœa from 116.1 to 95. At the fourteen unsubjected stations primary sores fell from 120.6 to 107.9; secondary syphilis rose from 31.6 to 31.8; gonorrhœa fell from 112.1 to 71.6. In 1880 to 1882, stoppage of pay having terminated, the ratio of primary sores at the protected stations was 75.6, secondary syphilis 26.6, gonorrhœa 99.0. At all the stations never under the Acts the ratio of primary sores was 123.0; that of secondary

syphilis 32.5; gonorrhœa 110.4. At the fourteen unsubjected stations the ratio of primary disease was 175.9, of secondary syphilis 38.9 and of gonorrhœa 128.4.

The Acts were suspended in 1883, and wholly repealed subsequently; the separation of the tables has not been continued since 1884. The ratios of disease among all the troops are as follows:

	Primary Sores.	Secondary Syphilis.	Gonorrhœa.
In 1860, ratio per 1,000 of admission	140	36	133
In 1885, ratio per 1,000 of admi-sion	127	27	121

From this it will be seen that the ratio of disease has returned to what it was in 1860 before the first Act was enforced.

There are many other interesting points in Inspector-General Lawson's paper which show immense pains, great research and a most thorough knowledge of the whole subject. Enough, the *Lancet* says, has been given to show the benefits of the Contagious Diseases Acts and the disastrous results of their repeal.

Cotton and Collodion Dressing for the Chest.

In the *Annals of Gynecology and Pediatics*, February, 1891, there is a letter from Dr. William Hunt, of Philadelphia, on a new method of dressing the chest in pneumonia, pleurisy, pleurodynia, etc. Dr. Hunt says:

This is the method I advise to dress the chest in a case of pneumonia, pleurisy and pleurodynia. Do it on a large scale, in the same way that we now dress abrasions and bruises. If there is to be any cupping or other preliminary operation, have that attended to; then all the ingredients wanting are pure collodion and absorbent cotton in smooth layers, and a good broad brush, like mucilage brushes. Apply a very thin layer over the side affected from spinal column to sternum, and secure it with collodion smeared thoroughly over it. Then go on with thicker layers, securing them with collodion until a good padding is obtained, paying particular attention to the edges. In double cases you can act accordingly. The advantages are:

1. The one dressing, if well applied, will last throughout the case, and so

2. The fatigue and discomfort of frequent poulticing are avoided.

3. The side, in single cases, is held as in a splint, while the free side does the breathing. A first-class non-conductor is covering the chest. I am not sure but that the contracting collodion may have some influence in controlling the blood supply.

4. There is no particular interference, in one who has a good ear, with physical examination. Maybe it would be a good thing if there was; for, having once made the diagnosis, what is the use of exhausting the patient every day by trying to find out whether one-eighth of an inch, more or less, is involved? The general symptoms will tell that.

Calomel and Salt.

The *Western Druggist*, February, 1891, says: Calomel and salt are by many believed to be incompatible on account of the alleged formation of mercuric chloride. This theory has often been contradicted, but Paul Adam has conducted a fresh series of experiments, the results of which he has recently reported. He boiled together calomel and salt in open and in closed vessels, in the presence of gastric juice, and the extract of beef. He also experimented with animals. His conclusions are: Boiled together in open vessels with the alkaline (especially ammonium) chlorides, calomel yields mercuric chloride. Under exclusion of the atmosphere, however, even in the presence of organic matter, no corrosive sublimate is formed. Hence there is no danger in the administration of these two agents together.

Study of Medicine in Thibet.

The *British Medical and Surgical Journal*, February 5, 1891, says: The Buddhist Lamas' University, in the Transbaikal Province of Thibet, has a medical course of ten years. According to *Nature*, a traveler named Ptitsyn has returned from that country with a collection of medical books and drugs illustrative of the knowledge and the methods of practice in Thibet. Mr. Ptitsyn remarks that he has found over one hundred diseases described in the Buddhist literature, and of these a mythical origin is ascribed to only two. Strictly medical subjects are not studied until the fifth year of the course, the first four years being devoted to the study of the languages and theology. The eighth year is devoted to astrology, and philosophy is studied in the last two years.

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The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

PELVIC INFLAMMATION AND THE GENERAL PRACTITIONER.

The pathology of pelvic inflammation is settled beyond cavil. Non-puerperal pelvic inflammation is peritonitis, non-puerperal pelvic cellulitis does not exist, or exists only as a curiosity—resulting from traumatism and infection of the pelvic connective tissue. These statements are also nearly true of puerperal pelvic inflammation. Puerperal peritonitis is common; puerperal cellulitis is rare. It is also equally well known that pelvic peritonitis almost invariably means salpingitis with infection of the peritoneum by discharge of the tubal contents at the fimbriated end of the tube; and that recurring attacks of pelvic peritonitis are due to leaky tubes. Other causes of pelvic peritonitis are changes taking place in pelvic tumors, especially dermoid cysts, traumatism and perhaps the effect of exposure at the menstrual periods. These facts have been known for thirty years, having been discovered by Bernutz, and they have been demonstrated fully by the surgery of to-day.

It is also equally well known that chronic pelvic peritonitis does not tend to a natural cure, and that recurrences of acute peritonitis are characteristic of the disease, being due to leakage from the focus of poison, the diseased tubes. The natural end of such cases is invalidism or death during a recurrent acute peritonitis. Experience has shown that medical treatment, while affording much palliative benefit, is inadequate to effect a cure. Ablation of the diseased uterine appendage or appendages, the focus of the disease, is the only treatment offering a radical cure. When operation is done early, before the patient is a wreck, the immediate risk to life is slight, less than five per cent., and prompt restoration to health follows. Operations done on such diseased structures does not in any way lessen the fecundity of women; they are sterile by reason of the disease. It restores such sufferers to health and usefulness; saving some from invalidism and others from death. These facts are now amply demonstrated and are opposed only by those in the profession who object to exerything which has not the stamp of antiquity upon it.

What, then, becomes the duty of the practitioner when called to attend these cases? To recommend operation by skilful hands. No more pressing duty devolves upon him, and it is time that the matter is brought home to the practitioner. He should know and feel that he is neglecting his duty when he puts such cases to bed, treats the acute attacks by opium internally and poultices externally; and between attacks paints the vagina with iodine and inserts the glycerin tampon. Such neglected cases are brought later to the surgeon either as broken-down wrecks, or as women dying with suppurative peritonitis. These are the "too late" cases. Either their nutrition is so profoundly depraved that they require months to recu-

perate, or being past recuperation they remain wrecks, or swell the death-list of the surgeon who is too conscientious to refuse them a last chance. Hereafter the responsibility for such maltreatment will rest with the family physician.

The cases in which hesitancy may be felt are cases of slight or catarrhal salpingitis, in which the fimbriæ are not agglutinated, and in which accumulation of tubal secretions has not occurred. These cases are subjects for watchful care. Such of them as progress from bad to worse may be referred to the surgeon. The others are fair subjects for medical treatment, so long as life is threatened by attacks of peritonitis.

THE TONGUE IN SCARLET FEVER.

Authorities differ as to the constancy and diagnostic significance of the appearance of the tongue in scarlet fever. Upon the suggestion of Prof. Fürbringer, Dr. Neumann made a series of observations on the tongue in forty-eight cases of scarlet fever at the Friedrichshain Hospital, at Berlin, and records in the *Deutsches Archiv für Klinische Medicin*, January, 1891, the results of his investigation.

The changes in the tongue presented themselves in three stages. In the first, the mucous membrane became swollen, and the tongue was enlarged and corrugated on its surface, while the epithelium became cloudy. The tongue also presented the appearance of being heavily coated, except at the tip and margins. In the second stage, desquamation took place. This was most marked at the surface of the fungiform papillæ, and gave rise to the characteristic appearance of the strawberry tongue. In the last stage restoration of the epithelium took place, at times with such rapidity as to cause the tongue to again appear coated. Naturally, deviations from this typical course occurred. These could be explained by antecedent or complicating conditions.

The characteristic appearances of the tongue presented themselves in thirty-eight of the forty-eight cases, carefully inspected at intervals of two or three days—that is, in seventy-nine per cent. In six cases, no appreciable changes occurred. In five of these there had been digestive derangement or septic intoxication; while in the remaining one no complicating condition could be discovered.

In the majority of the cases, desquamation took place from the third to the fifth day of the disease and left for more than four days longer the strawberry tongue which, in twelve cases, was still present on the fourteenth day. Thus in a third of the cases, the strawberry tongue disappeared during the first week; in another third, during the second week; while in the remaining third it was still present at the end of the second week. There was no relation observed between the intensity of the changes in the tongue and those in the skin.

From the foregoing, it may be concluded that the appearances of the tongue in scarlet fever constitute a characteristic, though not a constant feature of the disease.

EPILEPSY AND ALYLENE HYDRATE.

Notwithstanding the fact that many remedies have been from time to time brought forward for the treatment of epilepsy, the bromides yet remain the most trustworthy and most effective at our command. There are, however, certain cases in which the bromides absolutely fail to render any service, or in which for one reason or another they are not well borne. For these cases, it would be desirable to have a remedy that could at least be used to alternate with, if not as a substitute for, the bromides. Stimulated by the results recorded by Wildermuth, in the *Neurologisches Centralblatt*, No. 15, 1889, from the use of amylene hydrate in the treatment of epilepsy, especially when the attacks were frequent, Dr. Richard Drews, of Altona, determined to try the remedy in just such a case, and in the *Mit-*

chener medicinische Wochenschrift, January 27, 1891, he reports the disappointing and unfavorable results he obtained. The case was a typical one of epilepsy, in a woman thirty-five years old, without other neurotic history, in whom the attacks had begun at twenty years of age, and had continued with gradually increasing frequency. Bromides and chloral had been used without avail. Finally, resort was had to amylene hydrate, twenty-five grains three times a day. The attacks increased in frequency, one following each administration of the remedy, the appetite failed and there was severe headache and sleeplessness.

In view of this experience it seems as if amylene hydrate was of little use and that the bromides are yet the best remedy in the treatment of epilepsy. Perhaps too much disappointment should not be felt, and experimentation with amylene hydrate should not be wholly abandoned, because it may be suited to some cases, if not to others; but the experience of Drews certainly tends to dampen the ardor caused by Wildermuth's reports.

MEDICAL AND SURGICAL COLLEGE OF NEW JERSEY.

In the REPORTER for January 10, 1891, we called attention to resolutions in regard to the so-called Medical and Surgical College of New Jersey, adopted by the Hudson County Medical Society, and referred also to the exposure of the methods of this College made in the REPORTER as long ago as August 24, 1889. It is pleasant now to be able to report that—largely through the efforts of the State Board of Medical Examiners of New Jersey—the charter of the institution mentioned has been repealed by the Legislature, and the repealing act has been approved by Governor Abbett.

We heartily congratulate the New Jersey Board of Medical Examiners upon this fruit of its labors so soon after it came into existence. The institution just abolished was largely made up of electics, who, so far as we can tell, have somewhat different standards of professional and general excellence from those which prevail in the regular profession.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the REPORTER.]

DISEASES OF THE EYE. By EDWARD NETTLESHIP, F. R. C. S., Ophthalmic Surgeon to St. Thomas's Hospital, etc. Fourth American from the Fifth English Edition. 12mo, pp. 500. 164 illustrations. Philadephia. Lea Brothers & Co.

This excellent manual, designed as an introduction to the study of eye-disease, seemed at its first appearance the most concise, direct and practical presentation of the subject to be found in the English language. Each edition has showed distinct improvement, and the present gives evidence that the revisions have been careful as well as numerous. Much that at first seemed merely implied and to be read between the lines, but only by one already familiar with the subject, is now clearly and explicitly stated; and, while brevity gives a dogmatic character to many of the opinions set forth, there is only gain to the learner in this. He is not left halting between two opinions; and he can accept, as well-grounded, every view of this careful, experienced and conservative author. A few errors have escaped elimination in the revision, and a few statements are open to criticism. Thus under "optical conditions of clear sight," p. 40, it is stated that an object must subtend an angle of 5 minutes, in order that its form may be perceived. This is true of square letters like Snellen's, as stated on p. 48; but does not hold for simpler forms. Objects and spaces of 1 minute ought to be distinguished in good in-door light. In the designation of prisms the numbering by the actual deviation produced seems to be ascribed to Maddox, instead of to Jackson; and no mention is made of the metric designations of Dennett and Prentice, which complete the reform which ought to be made. The "pseudo-coloboma" of the iris may be upward or in any direction; so the statement is incomplete that coloboma "is always downwards." The table of prisma ic effect of decentering lenses quoted from Maddox, notes on spring catarrh, pemphigus of the conjunctiva, corneal transplantation, etc., bring the work up to date; and by the substitution of new cuts and in its general typography this edition seems an improvement on the last. On the whole, this book may be said to fully deserve the warm welcome which it has already received, and to be worthy of hearty recommendation to the profession.

ÉTUDES SUR LA RAGE, ET LA METHODE PASTEUR. PAR LE DR. LUTAUD, Rédacteur en Chef du *Journal de Médicine de Paris*. 2d Edition. 12mo, pp. x, 440. Paris. *Journal de Médicine de Paris*, 1891.

This second edition of Dr. Lutaud's book on hydrophobia comes at an interesting time, when he finds himself engaged in combating the extravagances of the claims of Koch's followers. The extremes to which Pasteur and his disciples have pushed his notions in regard to the so-called protective inoculations against rabies, have found a curious counterpart beyond the Rhine, and as Pasteur's claims found little

recognition there, so in turn have the claims of Koch been coldly received in France. It may be yet that Lutaud will devote himself to collating the failures and fallacies of the Koch method, as in the book before us he collates the failures and fallacies of Pasteur's method. One who reads this book will see in it, however, intimations of something worse than failure and fallacy—that Pasteur has been guilty of misrepresentation, and has made the discoveries which were exploited as humane and scientific, the means of acquiring wealth as well as universal fame. It will be seen here, likewise, that nothing, against which Pasteur has proposed a sure preventive, has been prevented, and that the diseases of the vines, the diseases of the silk-worms, the diseases of the dogs, the diseases of cattle still ravage France and other lands formerly exposed to them; and he who looks for success in connection with Pasteur's brilliant claims will find them principally in the fortune which he has amassed and the reputation which he has secured. In this there is no claim that Pasteur has not been industrious and ingenious, and from the scientific standpoint a very useful investigator; but it appears that whenever he has passed from the field of the investigator and has attempted to make any practical application of his theories, the result has been more brilliant than lasting, and is likely to serve rather as a warning than as an example.

SUGGESTIONS TO THE MEDICAL WITNESS. By J. S. WIGHT, M. D., Professor of Operative and Clinical Surgery at the Long Island College Hospital, Brooklyn, N. Y. 12mo, pp. 228. Cambridge: Printed at the Riverside Press. 1891.

Dr. Wight has written a very readable book on a very important subject. It is so common now for medical men to be summoned as expert witnesses that it is as important for them to be as well prepared for the trying duties of the situation as possible. Unfortunately many medical witnesses go on the stand without any previous experience, and with no better preparation than a desire to do justice and bear true witness. While this is the most important prerequisite, of course, for good testimony, it is, nevertheless, a fact that the position is often trying because of its mere novelty, and more often trying because of the harrassment of the witness by the attorneys. To be forewarned in regard to the difficulties of the situation would be, in many cases, to be forearmed; and the recorded experience and opinions of a man like Prof. Wight cannot fail to be helpful.

LITERARY NOTES.

—P. Blakiston, Son & Co. announce for early publication, "*A Handbook of Local Therapeutics*," being a practical description of all those agents used in the local treatment of disease, such as Ointments, Plasters, Powders, Lotions, Inhalations, Suppositories, Bougies, Tampons, etc., and the proper methods of preparing and applying them.

The diseases which chiefly require local treatment are those of the Respiratory Passages, Ear, Eye, Skin, together with certain general surgical affections, including the Diseases of Women. In order, therefore, that the various uses of each remedy may be thoroughly set forth the following gentlemen have assumed the authorship: Harrison Allen, M. D., Emeritus Professor of Physiology in the University of Penna.; Laryngologist to the Rush Hospital for Consumption; late Surgeon to the Philadelphia and St. Joseph's Hospitals. George C. Harlan, M. D., late Professor of Diseases of the Eye in the Philadelphia Polyclinic and College for Graduates in Medicine; Surgeon to the Will's Eye Hospital, and Eye and Ear Department of the Pennsylvania Hospital. Charles B. Penrose, M. D., Surgeon to the German Hospital; Instructor in Clinical Surgery, University of Pennsylvania, and Arthur Van Harlingen, M. D., Professor of Diseases of the Skin in the Philadelphia Polyclinic and College for Graduates in Medicine; late Clinical Lecturer on Dermatology in Jefferson Medical College; Dermatologist to the Howard Hospital.

Each remedy will be taken up in alphabetical order, and after a succinct description of their pharmaceutical properties, by Dr. George I. McKelway, will be considered with reference to the local treatment of the affections above outlined. The authors believe that the information contained in this work will not be found elsewhere. The activity in the various lines of special medicine is one of the most striking phases of the times, and has materially changed many of the older methods of treating disease by local means. The greater part of the literature which has appeared is not accessible to most physicians. The *Handbook*, it is believed, will be of value to general practitioners as well as to those who, like themselves, are especially interested in sub-divisions of the clinical field.

The work will form a compact volume of about 400 pages, arranged in a manner to facilitate reference and containing, besides the usual index, a complete index of diseases, that will greatly enhance its usefulness.

—A few months ago the *Home-Maker* underwent changes which improved its appearance and intrinsic value very materially. The number for March, 1891, is a very good specimen of the American monthly magazine. It is well printed on handsome paper, and fully illustrated, largely by means of process pictures. It contains articles of great interest, among which may be mentioned, "Sheep in California," the "Study of American Republics" and one on the "Burrows of the Prairie Dog." This magazine is edited by the well-known writer, "Jennie June," and contains considerable matter especially interesting to women. The subscription price, $2.00, is so moderate that it ought to have a large circulation.

NOTES AND COMMENTS.

American Academy of Medicine.

The Sixteenth Annual Meeting of the American Academy of Medicine will be held at Washington, D. C., May 2–4, opening at 3 P. M., May 2.

As it is just previous to the Sessions of the American Medical Association, members will be able to attend both meetings.

Hiccough Cured with Nitrate of Amyl.

Last February a young woman of Shelton, Connecticut, had a prolonged attack of hiccough which seriously imperilled her life, despite the physician's efforts. In conse-

quence of the circulation given the case in the newspapers, remedies were sent from all parts of the country. Many were tried, and that suggested by Frank W. Mack, of the Associated Press, New York, was effective. The remedy was nitrite of amyl, a few drops to be inhaled from a handkerchief. On February 10, it was announced that the young woman was out of danger.

Simple Treatment of Ingrown Toenail.

The *Pittsburgh Medical Review*, February, 1891, cites Dr. Puerckhauer (from the *Münchener med. Wochenshrift*) as recommending a simple, and at the same time competent treatment for ingrown toe-nail.

A forty per cent. solution of potassa is applied warm to the portion of the nail to be removed. After a few seconds the uppermost layer of the nail will be so soft that it can be scraped off with a piece of sharp-edged glass; the next layer is then moistened with the same solution, and scraped off; this must be repeated until the remaining portion is as a thin sheet of paper, when it is seized with a pincette and lifted from the underlying soft parts and severed from the other half. The operation does not require more than half an hour's time, is painless and bloodless, while the patient is delivered from his suffering without being disabled even for an hour.

Dietetic Employment of Fat.

W. Zuntz has a paper on the dietetic employment of fat in the *Therapeutische Monathefte*, October, 1890. He was induced to put to the experimental test of some conditions of digestion of fat, a preparation of chocolate suggested by von Mering. The chocolate is so made that it possesses a sufficient quantity of free fatty acids to form a permanent emulsion, without in any way injuring the taste of the chocolate. In order to find out whether the digestibility of fat is enhanced by the power to form an emulsion, Zuntz sought to find out what quantity of cacao butter, with and without the addition of fatty acids, was appropriated when administered to dogs. The result was, that there was an increase in digestibility, which was only slight—two per thousand of the fat—if moderate quantities of cacao butter were cooked with the rest of the food, but it was considerable if (as is usually the case with cod-liver oil, in order to avoid stomach digestion) the cacao butter was given some time before the rest of the food and in somewhat greater quantities. In the latter case, there appeared in the stool 9.9 per cent. of pure cacao butter, and only 6.1 per cent. of the emulsionized.

Corresponding to the result of the emulsionizable cacao butter in dogs, the fat of Mering's chocolate proved to be very digestible in men. For three days a moderate diet poor in fat, consisting of bread and lean meat, was given, and, in addition, a daily quantity of 416 grams of chocolate containing 87 grams of fat. In the feces appeared only 4.88 per cent. of fat; whereas Weigmann, in a series of experiments with ordinary cacao butter, administering 53 grams, recovered 5.5 per cent. In comparison with the most used fats, and those fats prized on account of their being easily digestible, such as butter, lard, marrow, the fat of the chocolate preparation is seen to be considerably superior.—*Deutsche med. Wochenschrift*, Jan. 1, 1891.

Treatment of Stricture of the Ileo-cæcal Valve.

In the *Bulletin Médical*, December 31, 1890, Prof. Péan has a lecture on the treatment of strictures of the ileo-cæcal valve, in which we are glad to see that he is acquainted with Philadelphia work in this field, Barton's cases being referred to in some detail. Péan's operation consists in exposing by an incision the ileum at its junction with the cæcum, and occluding the bowel both above and below the valve with rubber tubes fastened with forceps. The tubes serve the double purpose of preventing hemorrhage and keeping fecal matter from circulating in the intermediate portion of bowel during the operation. The intestinal wall is then incised longitudinally over the valve for a distance of three and one-fourth inches. After washing the interior of the bowel with a one per cent. solution of carbolic acid, the condition of the valve is examined. If it is found transformed into fibrous tissue, and so retracted as to occlude the bowel, it is resected down to the muscular coat of the bowel. This done, the two extremities of the intestinal wound are brought together in such a way that the ileum and cæcum

are brought together. The opening in the bowel thus becomes lozenge-shaped instead of longitudinal, the two upper sides being formed by the ileum and the two lower by the cæcum; the sides are then approximated with the forceps, and are united so that the line of suture is transverse to the bowel. Péan thinks this method of operating possesses a number of advantages, especially as it establishes an ampullar dilatation at a point where before there was stricture.

Jefferson College's New Surgeon.

At a meeting of the faculty of Jefferson Medical College on March 9, Dr. H. Augustus Wilson was elected Lecturer on Orthopedics in the Jefferson Medical College and surgeon in charge of the Orthopedic Department of Jefferson Medical College Hospital, to succeed Dr. O. H. Allis, resigned. Dr. Wilson is Professor of General and Orthopedic Surgery in the Philadelphia Polyclinic and College for Graduates in Medicine, Lecturer on Orthopedic Surgery in the Woman's Medical College. The present success of the Polyclinic is due largely to his industry and enterprise, and his present appointment is probably a tribute to these same qualities.

The Law of Periodical Function in Women.

Probably no single function of the human organism has called forth so many hypotheses as the menstrual loss of blood, occurring in healthy women at regular intervals. Though many ingenious explanations have been proposed, none is entirely satisfactory. In the *Wiener medizinische Presse*, February 8, 1891, v. Ott reports observations, not exclusively upon menstruation, but upon the various vital processes occurring in women during the period of generative activity. These processes correspond in time to the hemorrhage, are associated conditions, with a dependent relation to it. Observations upon temperature, pulse and blood pressure indicated that vital activity attained its maximum preceding the menstrual period and declined at its commencement or immediately before. Sphygmographic tracings, muscle strength, and excretion of urea suffer similar variations. Observations were made at a certain hour each morning during prolonged periods, sometimes extending into the menstrual periods, upon heat radiation, muscle strength, pulmonary capacity, inspiratory and expiratory force, the tendon reflexes, in healthy women placed under the same condition; and a physiological functional periodicity of the female organism was demonstrated. To establish the connection between menstruation and this periodicity of function, it is necessary to determine if the rhythmical variations are independent of menstruation. A large number of observations made by Dr. Schichareff, under the guidance of von Ott, upon pulse, temperature and blood pressure, in girls between the ages of eight and thirteen years, and in women between the ages of fifty-eight and eighty years, showed that no such periodical variations of physiological functions occur in females during the periods in which they are not capable of conceiving, and in which they do not menstruate.

Teeth in Diabetes.

The importance of early diagnosis in diabetes cannot be over-estimated, because the prognosis may be much influenced by the institution of early treatment. It is interesting, therefore, to call attention to the fact that the *Wiener medizinische Presse*, January 4, 1891, contains a brief abstract of a publication by Magitot in *Bulletin médical*, in which he dwells upon the diagnostic significance of alveolar osteo-periostitis as a manifestation of diabetes. He has noticed, in this disease, a deviation of the tooth, which, later, becomes loosened. At the same time an alveolar catarrh exists. Ultimately the tooth falls out. In the further course of the disease, the alveolar border of the bone may be absorbed, and this in turn may be followed by gangrene of the gum.

Druggist's Error in Germany.

The *Chemist and Druggist*, January 31, 1891, says: A singular case in connection with a mistake in dispensing is now occupying the attention of the Berlin authorities. Some time ago a prescription was presented to the assistant at a Spandau pharmacy ordering a draught composed of sodii nitrat., potas. bromid., aq. dest., and syr. mannæ, for a child. The assistant by mistake dispensed spirit of camphor instead of the distilled water, but the error was discovered after the administration of the first dose to

the patient, and no ill results followed. But the father thought he would try to make some capital out of the mistake, and threatened the pharmacist with exposure, demanding first 3,000 marks as hush money, and, when that was refused, dropping his price for secrecy to 140 marks. But the chemist declined to compromise, and the father wrote about the mistake to the local press. The police got wind of the affair, and they are now killing two birds with one stone. The chemist's assistant was prosecuted for causing bodily injury through carelessness, and fined 50 marks, and the would-be blackmailer is being dealt with for the more serious offense of trying to commit illegal extortion by threats.

Congress of American Physicians and Surgeons.

Congress of American physicians and surgeons will hold its second triennial meeting in Washington, D. C., September 23–25, 1891, under the presidency of Dr. S. Weir Mitchell, of Philadelphia. The vice-presidents, *ex-offico*, are: The president of the American Surgical Association, Dr. Claudius H. Mastin, of Mobile, Ala.; the president of the American Ophthalmological Society, Dr. Hasket Derby, of Boston; the president of the American Otological Society, Dr. Gorham Bacon, of New York; the president of the American Neurological Association, Dr. Wharton Sinkler, of Philadelphia; the president of the American Gynæcological Society, Dr. A. Reeves Jackson, of Chicago; the president of the American Dermatological Association, Dr. Francis B. Greenough, of Boston; the president of the American Laryngological Association, Dr. William C. Glasgow, of St. Louis; the president of the American Climatological Association, Dr. Frederick I. Knight, of Boston; the president of the Association of American physicians, Dr. William Pepper, of Philadelphia; the president of the American Association of Andrology and Syphilology, Dr. Fessenden N. Otis, of New York; the president of the American Orthopædic Association, Dr. Newton M. Shaffer, of New York; and the president of the American Physiological Society, Dr. Henry P. Bowditch, of Boston. The chairman of the Executive Committee is Dr. William Pepper, of Philadelphia. The treasurer is Dr. John S. Billings, of the army. The secretary is Dr. William H. Carmalt, of New Haven. The subjects for report and discussion mentioned in the preliminary programme are as follows.

Tuesday, September 22, 3 P. M.—Conditions underlying the Infection of Wounds, including a discussion of Disinfection with Reference to the Treatment of Wounds, of the Relation of Bacteria to Suppuration, of the Resistance of Tissues to the Multiplication of Bacteria, and of the Effects of Antiseptic Agents on Wounds. Referee, Dr. William H. Welch, of Baltimore; co-referee, Dr. Roswell Park, of Buffalo. The discussion will be adjourned if necessary until Friday afternoon.

Wednesday, September 23, 3 P. M.—The Late Manifestations of Syphilis. Referee, Dr. Phineas S. Conner, of Cincinnati; co-referee, Dr. Abner Post, of Boston.

Wednesday evening.—The president's address, to be followed by a reception.

Thursday, September 24, 3 P. M.—Fibroid Processes (Chronic Interstitial Inflammation, Scleroses); their Pathology and Ætiology, with Special Reference to the Influence of Diathesis and Heredity. Referee, Dr. Alfred L. Loomis, of New York; co-referee, Dr. William Osler, of Baltimore.

Friday, September 25, 3 P. M.—If necessary, the discussion on The Conditions underlying the Infection of Wounds, etc., will be resumed.

Is Sterility a Disease?

The Medical Press, February 25, 1891, says: A civil record has recently been tried in Dublin before Mr. Justice Holmes and a jury in which an enunciation of the law was made by the judge which is of much importance to the profession, and which raises very interesting considerations. The suit was instituted by a Dublin physician to recover fees to the amount of 19 guineas for attendance upon the wife of a solicitor. The lady, it appeared, suffered from no other disease save sterility, but anxiously desired a cure for this condition and sought advice with this object, whether with or without the knowledge and consent of her husband was not clearly proved. The physician attended and made many examinations by speculum and sundry applications of sponge tents and other instruments for the purpose of dilating the cervix uteri. The lady's husband refused to pay on the ground that the treatment of his wife for the

cure of sterility was not a "necessary" for which the law required him to pay, and on the additional ground that the physician's attendance took place without his knowledge or consent, but this latter plea may be taken as formal. The law laid down by Mr. Justice Holmes in his charge to the jury, which we regret to say has not been reported in the newspapers, is as follows: 1. Every man is bound to provide necessary medical care for his wife in case of sickness. 2. Every husband is liable for payment of fees in case of such sickness, whether he knows of the attendance on his wife or not; but, 3, Sterility is not a sickness for the treatment of which a husband can be made liable. It does not shorten life, nor prevent the carrying out of household duties, nor cause physical pain. Therefore medical attendance for the remedy of such condition is not a "necessary" within the meaning of the law, and the physician, in this suit, was unable to recover the fees due to him. It should be added, however, that he could still recover against the separate estate of the wife, if she had any, for "work and labor done" though the "work and labor" might not be legally "necessary," as against the husband. This decision raises a distinction between a sickness and an abnormal condition which we have not seen previously defined in a court of law, and it is interesting to consider how far the definition extends. For instance is a nævus, or a wart on the back, such a condition as the law would consider to require "necessary" attendance? None of these shorten life, none of them prevent the carrying out of domestic duties, and none of them cause physical pain, and yet they have always been considered as subjects for medical and surgical treatment, but, if the dictum of the learned judge in this case is to be trusted, of which we have no doubt, practitioners will find it necessary, in future, to secure themselves in such cases, by a definite contract with the husband before they enter upon attendance of the wife.

Infusion of Roses for Diarrhœa.

Dr. A. V. Alexeevski (*Bolnitchnaia Gazeta Botkina*, December, 1890) says that preparations of rose petals have usually been used only as vehicles, but never as an independent medicament. He found the infusion of flores rosarum an excellent therapeutic agent, especially in diarrhœa. Only chronic cases were chosen, which did not yield to any ordinary treatment known for diarrhœa. The infusion was prepared by putting a handful of the dried leaves in a glassful of hot water and keeping the mixture covered in a warm place for about two hours. To adults from two to three glassfuls of the infusion were given; to children a glassful in divided doses during the day. The best results were obtained from flores rosæ rubiæ; the infusion of flores rosæ centifoliæ was found weaker in its action. It is better not to add any sugar to the infusion as it only gives the infusion an unpleasant taste.

Three chronic cases are stated to have been permanently benefited by the above treatment. One patient was a middle-aged woman, and two were children of three and a half and two years old respectively.

The beneficial action of the infusion is due, first, to the presence of tannin, and second to the volatile oils, oleum rosarum being one of them. The latter possesses antiputrifactive and anti-fermentative properties. The preparation of the red rose is recommended to be used for children.

Primary Pyemia.

Primary pyemia, *i. e.*, pyemia without any apparent focus for the primary supply of infectious matter to the general system, is very rare. Dr. L. P. Alesandroff, in the *Bolnitchnaia Gazeta Botkina*, October 17 and 24, 1890, relates the history of an interesting case of this form of pyemia in a young boy who was under his charge.

The boy was ten years old, with a negative family and personal history. December 2, 1890, he fell on the floor and hit his knee slightly. It did not give him any pain, even immediately after the fall. December 4, he began to complain of slight pain in his knee and general malaise. He had no special treatment until December 6, when high fever was discovered, after which he was sent to the hospital. On admission the child was found in a condition of septicemia. The leg and foot on the side of the injury presented all the signs of acute infectious osteomyelitis, for which Alesandroff immediately performed an operation. On the following day the patient was very restless, began to fail rapidly, and died in the night.

The *post-mortem* examination disclosed old

pleuritic adhesions, hemorrhagic faci in the lungs and in the cardiac pericardium, changed in some places into pus, purulent arthritis, limited osteo-myelitis and purulent cellulitis in the leg. All the appearances were those of acute and recent disease, and it appeared impossible to regard any of the pathological points as the original source through which systemic infection had taken place.

Alesandroff says that the general septic condition developed entirely independently of the slight injury received to the joint. He supposes that, in this case, a number of germs found their way into the system, and having met with little or no resistance of the tissues caused the general blood poisoning. Falls and injuries in children are an every-day occurrence, and he thinks that, in similar cases, it is not justifiable to look upon a slight fall or injury as being the cause of acute septicemia. He refers to a similar case reported by Prof. Kohts, in the *Deutsche Medicinische Wochensch.*, 1887.

Another such case is reported by Dr. R. R. Ball, in the *New York Medical Journal*, February 14, 1891, under the heading "Case of fatal septicemia following contused injury to the thumb in a strumous subject."

An Appliance to Facilitate the Insertion of the Soft-Rubber (Nelaton's) Stomach-Tube.

Dr. Gustave Liebmann, Attending Physician to Patients with Stomach Diseases, North End Dispensary, Boston, says, in the *Boston Medical and Surgical Journal*, March 5, 1891: In the every-day use of a stomach-tube the soft elastic (Nelaton's) tube is by general agreement the one to be preferred. Although the hard gum tubes enter the pharynx and œsophagus much more readily, they are at any rate relegated to the rarer cases of poisoning with suicidal intent, where, from obvious reasons, the application of a soft tube is not feasible. In all applications of a tube for diagnostic or therapeutic purposes we use the soft kind, as it is well-nigh impossible to do any mischief with them, and they "sit" much easier in the stomach, giving rise to less irritation or gagging than a hard tube. Still the introduction of a soft tube is at times, although generally not difficult, a source of great annoyance to both physician and patient. And why? Because for the passage of the instrument from the fauces to the beginning of the œsophagus we have to depend on the intelligence and docility of the patient. He has to swallow the tube and work it through the pharynx, and only then are we enabled to push it down to the cardiac orifice. Should the patient from some cause (awkwardness, nervousness, and so on), fail to swallow, as it happens in some exceptional cases, then we are helpless and have to give up the job. Now to overcome this difficulty I have during the last three months used a simple appliance, that served me exceedingly well.

Although I designed the stylet and had it made to suit my fancy, I must state that the conception of it I got from a lady patient, returning from Professor Leube, in Wurtzburg, who told me that the doctor used some sort of a staff to steady the tube. The stylet is made of rattan, is about thirty-four inches in length, to fit that of the ordinary Nelaton, and to project besides one and a half to two inches at the proximal end, is well smoothed down, of the thickness of a No. 6–8 English catheter (according to the caliber of the tube), with one end curved like the beak of a metallic bougie, but of uniform thickness from one end to the other.

The curved end of the well-lubricated stylet is inserted and pushed forward through the tube, until it arrives at the distal end of the latter, care being taken that no part of it protrudes through any one of the openings at the end of the tube. It is advisable to bend tube and stylet still more into the requisite curve before inserting in the fauces. This done, the tube, with the stylet sticking out at the proximal end, is cautiously inserted—like any other hard-gum tube—into the fauces and pushed forward along the pharynx to a point corresponding with the lower border of the cricoid cartilage, or in other words, to the beginning of the œsophagus, when the stylet is withdrawn, and the tube slid down to the cardiac orifice without any further trouble. You see the soft tube is changed into a stiff one but for the short minute during which it has to pass the pharynx; we remove the stylet, and have to deal with a soft tube during the remainder of the whole procedure.

I would warn against allowing the stylet to remain within the tube below the mentioned limit, as, in the first place, we don't want to use a hard tube in the œsophagus, and second, the withdrawal of the stylet under this condition would be almost impossible. At any rate, our end in view—

the overcoming of the difficuly to the passage of the Nelaton tube—is fully reached by using the stylet only as far as the pharynx extends.

I would claim, therefore, that the stylet fulfils all the requirements of the case, dispenses with the co-operation of the patient, and that there should never be any further failure, the patient being willing and there being no organic stricture present, in introducing a soft-rubber tube into the stomach.

Fractured Ribs in the Insane.

A paper of much interest upon the subject of fractured ribs of the insane has been contributed to the last volume of the *St. Bartholomew's Hospital Reports*, by Dr. Claye Shaw. It discusses in the first place how it is that fractures occur. The author states that the detection of broken ribs in lunatics is not necessarily proof of violence on the part of an attendant, because it is difficult to imagine that attendants who know so well the consequences of being detected in any act of violence would deliberately, and for no reason, commit one so easily found out. Seemingly, it is right to say that fractures in the ribs of lunatics are not caused by hard direct blows, but by a slighter force which happens to take the patient when his body is placed at a disadvantage for resisting strain. Hence the absence of a bruise and the difficulty in finding out how these injuries occur. Dr. Shaw bases this opinion upon the fact that prize-fighters rarely receive any injuries to the ribs, although immense blows may be given upon the thorax, the explanation being that the body is in a position to resist the effect of the blow. After many experiments made by himself and Mr. Stansfield, Dr. Shaw ascertained that the breaking weight of a rib—the eighth—was among males, on the right side 15 11-16th lbs., and on the left 16¼ lbs.; among women it was 10⅜ lbs. on the right side, and 9½ lbs. on the left. He summarizes his results as follows: (1) That a considerable difference is found to exist not only in the weight of the ribs on the two sides of the body, but also in the average breaking weight. (2) That the lighter rib is often found to bear the heavier weight, and that there is no proportion between the weight of the rib and the number of pounds it is capable of sustaining, whence it would appear that physical conditions of structure have more to do with the strain-resisting power than has chemical change in bones. (3) That persons suffering from disease of the heart or blood-vessels bear less strain than others. (4) That persons suffering from advanced constitutional disease, such as phthisis, may have ribs that support a strain much above the average, and hence that there is no direct relation between constitutional strength and that of the ribs. (5) That when a blow causes a fracture this is dependent not so much on the weight of the rib and its power of bearing strain as on other conditions. Lastly, he remarks that the dictum that the ribs of the insane are more brittle than those of the sane is true to a very limited extent only, and is almost confined to those affected with degeneration of the circulatory system. He appends a table to his paper showing the weight required to cause fracture of the rib and the seat of the fracture in forty-five experiments which he made.—*Medical Press*, February 25, 1891.

Acetanilid for Chancre and Chancroid.

The *Journal de Médecine*, January 25, 1891, states that Basilevitch reports in *Nouveaux Remèdes*, November, 1890, that cicatrization took place in a short time as a result of sprinkling acetanilid on the surface of the ulcers in one case of chancre in a woman and in two cases of chancroid in men.

In these cases, acetanilid has the advantage over iodoform of being inodorous, and that large doses do not give rise to toxic manifestations. It is also less expensive than iodoform—an important consideration, especially in dispensary practice.

Foreign Medical Diplomas in Illinois.

The Illinois State Board of Health has decided that hereafter it will recognize no foreign diploma unless such diploma confer the right to practice medicine in the country in which it was granted. This rule applies to Austrian, German, Russian and Swiss diplomas, unless the holders have passed the State examination which entitles them to practice in those countries. It applies also to Canadian diplomas unless the holder be a licentiate of the Colleges of Phyicians and Surgeons, of Ontario and Quebec.